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ABSTRACT

Such factors as values, traditions, customs, institutions, language, kinship systems, beliefs and skills are highly pertinent to the providing of mental health services. The report reveals allegations of serious abuse of cultural relevancy in serving Native Americans, questions what Native American mental health is and how it differs from non-Native American mental health, and illustrates through three case reports the complexities in serving Native Americans. While it is improbable that every mental health professional can have a detailed knowledge of the cultural situation of every client, it is possible for mental health professionals to have an awareness of general cultural factors which can expedite and enhance the delivery of services to Native Americans, such as Native Americans' familiarity with and skill in adaptive processes of problem solving and the use of concepts of pathology. Suggestions for meeting mental health needs of Native Americans include: securing increased participation of Native Americans in the mental health effort; developing coping skills which will enable Native Americans to identify conflicts and to select the available options for resolving the conflicts; and combining the roles of advocate, planner, and community organizer. (NEC)

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DELIVERY OF PSYCHOLOGICAL SERVICES TO NATIVE AMERICANS: HOW REAL IS CULTURAL RELEVANCY?

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DELIVERY OF PSYCHOLOGICAL SERVICES TO NATIVE AMERICANS: HOW REAL IS CULTURAL RELEVANCY?

I. BACKGROUND

Such factors as values, traditions, customs, institutions, language, kinship systems, beliefs and skills are highly pertinent to the providing of mental health services. These are the ingredients which must be identified and placed in perspective in order to serve the individual. Data collection, interpretation (diagnosing), treatment and prognosis all take place in a situation that is bounded and defined by what we collectively refer to as "social influences". Personal conflict is a consequence of cultural conflict. The alleviation of personal conflict is accomplished by use of aspects of the culture which are called resources. Recognition of these guidelines is necessary for the mental health professional to assist an individual seeking help. At the same time, knowledge of the social context is essential to safeguard the client from arbitrary and capricious intervention by mental health workers.

II. CONCERN FOR CULTURAL RELEVANCE

Awareness of cultural relevance. In view of the basic role of cultural factors in personal adjustment, why is there widespread interest in the contribution of cultural influences to personal adjustment. The interest is readily documented by a cursory review of the mental health literature. Causes for the interest are worthy of independent exploration, but may be generally viewed as a positive movement associated with growth in the mental health field (more persons provided with mental health services, development of more effective helping techniques).

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Questions of cultural relevancy have been raised especially in connection with serving "minority" groups. While all such subgroups of our multiethnic society have received some attention on this issue, our discussion focuses on the plight of Native Americans. There are allegations of serious abuse of cultural relevancy in serving Native Americans, charges which should be particularly disturbing to mental health care providers engaged in serving Native Americans. The more frequent complaints include:

1. MHP have only been agents to perpetuate the subjugation of Native Americans.
2. MHP have made no effort to understand the cultural background of Native Americans.
3. MHP have not tried to foster problem solving skills or develop constructive programs for Native Americans.

To the extent that these statements reflect the nature of mental health services for Native Americans, it is we as mental health professionals who have a problem.

Native American culture and mental health. Correction of such deficiencies in serving Native Americans would appear to demand an extensive exploration to find answers to such questions as what is Native American mental health (and how does it differ from non-Native American mental health) and which are the Native American cultural factors that are germane to mental health. Along with these questions, it would also be necessary to delineate the philosophy and goals of Native American mental health, such as how is pathology explained, what treatment procedures are applicable, when are the goals of treatment realized. It would seem to be a simple and straightforward

approach to learn Native American culture and then to apply these principles to serve Native Americans.

Unfortunately, traveling such a road is neither possible nor totally defensible when the magic of moonlight gives way to the brighter light of day. Some of the more evident contraindicators are:

1. There is no Native American culture; rather there are Native American cultures.
2. Culture is not a static and unchanging organization of variables; rather it is a set of procedures and ways for meeting life demands.
3. Within any unique subgroup (tribe) of Native Americans there is extreme variation in the cultural background of individual tribal members.

Some illustrative case reports. The complexities in serving Native Americans is illustrated by case examples.

Case #1 - 68 year old male; holds bachelors degree in religious studies; retired minister; complains of being unable to sleep; believes he has been put under a spell by medicine man so that he is unable to see clearly and "little people" prowl about his house to irritate and disturb him. (Choctaw)

Case #2 - Husband (27 years old) and wife (24 years old) requesting marital counseling. Both have completed higher education technical training. Husband is concerned that wife will leave him and take their children. Wife states that the cause of their conflict is because her husband "is not an Indian". (Both husband and wife are Native Americans but not from same tribe ; Chickasaw/Washoe)

Case #3 - Male, age 34 years, married, artist. Wants to get biofeedback relaxation training to increase percentage of B waves. (Pawnee)

Your problem is to identify the tribal affiliations of these persons.

III. RESOURCES AND PROBLEMS

Contemporary Native American cultural status. Data have been collected to support the contention that some Native Americans remain culturally distinct and the contention that some Native Americans are culturally indistinguishable from persons currently members of United Statesian middle class. This is a reflection of the ways different tribes have been able to survive and probably can be charted along a dimension of tribal cohesiveness-dispersion. It is tempting to suppose that a traditional way of living may be more associated with greater tribal cohesiveness, but this supposition must be validated as a necessary first step in serving any individual Native American. Serving those Native Americans whose beliefs and life styles are different from those of the "mainstream" norms poses profound ethical issues for human services professionals as to which set of guidelines is to be followed. In other instances, there is little doubt that many, if not most, Native Americans are struggling with living in two different worlds, an inherently conflictual condition.

Available resources. Mention has previously been made of the improbability that every mental health professional can have a detailed knowledge of the cultural situation of every client served (If for no other reasons, the time allowed and the fact that cultures change may prohibit such a realization). Nevertheless, it is possible for mental health workers to have an awareness of some general cultural factors which can expedite and enhance the delivery of services to Native Americans. Native Americans are familiar with and skilled in adaptive processes of problem solving. They have survived under the most difficult and trying conditions. Recognition of these skills

establishes a potent basis that can be used to cope with present problems (Often the Native American needs to be reassured about this). A second positive feature is found in the use of concepts of pathology (often to the surprise of many clinicians).

Although the names of the players may vary, the game is the same when Native American explanations of what causes maladjustment (illness) are compared with non-Native American explanations. The Anglo-European technical/scientific account of pathology as a disequilibrium is highly comparable to the Native American concept of disharmony with nature both hinge on a notion of balance. Native American ideas for maintaining health likewise bear a marked similarity (proper nutrition, meditation, self-regulation, desensitization). Agreement is also found in a common belief that there is an energy (force or power) for healing and good. Beliefs as to what must be done for healing also reveal a parallelism; take steps to restore the equilibrium/balance. (Allopathic medical treatment procedures are equally replete with ceremonials, herbs, cutting, ritual, faith, etc.). A growing awareness of common features in traditional and scientific healing systems has been the topic of a review by Rappaport & Rappaport (1981) who also indicate that similarities in the treatment approaches are most evident in the area of psychiatry.

Mental health problems of Native Americans. Having established a possible basis for serving Native Americans, it is appropriate to give some consideration to the kind of task to which we are committed. Major health problems identified in Native Americans include depression, alcoholism, diabetes, cancer, hypertension, malnutrition, lack of exercise, a sense of powerlessness, and environmental pollution. The same list could be used for the non-Native American population in the United States.

A closer examination of the mental health status of Native Americans reveals that maladjustments entail depression, unemployment, alcoholism, suicide, identity crisis and the "youth syndrome" (characterized by alienation, failure, negative self-esteem, poor academic achievement, low motivation). While some of these may be more severe or prevalent among Native American groups, the total picture is a close match for the profile of mental health problems for the general population of the United States with the possible exception of adjustment problems related to divorce.

IV. SUGGESTIONS FOR MEETING MENTAL HEALTH NEEDS OF NATIVE AMERICANS

Approaches to the problem. The effort to provide mental health services has been only a minor part of the total Native American health services, a situation that may also mirror the general pattern of health services. In their discussion of mental health services, Ryan & Spence (1978) point out that research shows no improvement in the mental health status of Native Americans despite increased programs. Ryan & Spence also report that the consumers have often been dissatisfied with the product. It is difficult to come to a clear conclusion regarding these findings. For example, it is possible that, even with the increases, resources required to get the job done are still deficient. Whatever variables may be involved, the providing of quality services remains the urgent concern of mental health professionals working with Native Americans. And while their efforts may have suffered from limitations in manpower, there have been attempts to change and introduce innovations as ways of improving services.

Native American involvement. Perhaps the most frequent area for change has entailed securing increased participation of Native Americans in the mental health effort. These programs are deserving of more than the cursory mention

given here out of consideration for brevity. One example is found in efforts to train indigenous members of a tribal group in professional skills in the hope that upon return to their people they will incorporate the skills in their particular cultural background. A somewhat similar method has attempted to provide professional workers with a knowledge of the culture of the tribal group served. In some instances, Native American health providers have been added to the Indian Health Service staff and made available to Native Americans, either by contractual arrangement or by direct assignment.

Thus far, movements to involve Native Americans in mental health services have resulted in only partially successful outcomes. The same approach applied with success to one tribe has failed when extended to another tribe (training indigenous professionals). In other instances, the effort has been mired in bureaucratic red tape (use of Native American practitioners). These disappointing results leave the matter of providing for the mental health of Native Americans an unfinished and challenging task.

An interim solution. Native American needs for mental health services are compelling and they have been documented. Efforts to develop effective service programs must continue. That continuation is assured if for no other reason by the policy of Indian self-determination. Preparation for self-determination may itself be a significant change for mental health workers (Jackson, 1981). Until self-determination can be implemented, there are huge tasks to be accomplished in the delivery of mental health services to Native Americans. The challenge is that of developing coping skills which will enable Native Americans to identify conflicts and to select the available options for resolving the conflicts.

Cultural relevance is crucial to meeting this task. In fact, much of the Native American's difficulties may be related to the necessity for having a

dual cultural status and the associated feeling of discontinuity, sense of powerlessness and loss of anchor. The discussion by Hammerschlag (1981) on the Native American's problems in developing a sense of personal identity is provocative and practical.

It is clear that the goal of human services providers must be that of assisting Native Americans to find coping techniques that are neither totally Anglo nor totally Indian but are rather a combination of these resources. Native Americans are in a state of transition. They have been squeezed to a point that there is little choice available to them if they are to survive. (Consider the economics of self-determination.) The problem may be constructively approached by confronting the client with the ambiguous situation and exploring the consequences and responsibilities associated with one or the other choice of worlds. The mental health professional is not justified in assuming or making the choice for the client. Once the choice has been made, the mental health professional must continue to work within the cultural guidelines selected by the client and seek to preserve and strengthen the chosen cultural style. This requires only moral courage and traditional mental health techniques (such as giving the appreciation entitled to any human being, listen, be genuinely interested in the situation, respect opinions, share planning, identify potentials, strengthen and develop potentials, help in the location of resources including spiritual, give training in problem solving, serve as a resource-consultant, and carry out monitoring/evaluation activities).

A less traditional approach requires creative courage and techniques which may not be in the bag of skills carried by some professionals. It has been outlined by Lewis (1981) who describes functions associated with three major

roles:

1. Advocate - negotiate, argue and debate the environment in behalf of the client.
2. Planner - assist in the creation of needed linkages between the tribe and other structures in the mainstream of society.
3. Community organizer - train tribal members in ways to construct tribal units which enable the tribe to participate in and pursue self betterment.

This is an exciting approach. Since it blends well with the policy of self-determination, in the future it can be expected to be more familiar to professionals engaged in providing culturally relevant mental health services to Native Americans.

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